Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $100.00 for date of service, 09/12/01.

   b. The request was received on 02/08/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. Initial Submission of TWCC-60
      1. Position statement
      2. HCFA 1500
      3. EOB(s)
      4. Medical Records
   b. Additional documentation requested on 06/11/02 – No response found in the file.
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. Initial Response not found
   b. Additional documentation requested on 06/11/02.
      1. Payment Screen
      2. HCFA 1500
      3. EOB(s)
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Notice of a Request for Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter undated

> "**FCEs are allowed a maximum of three times for each injured worker. FCEs shall be billed as code 97750-FC. FCE's shall be reimbursed at $100 per hour for a maximum of five hours for the initial test and two hours for an interim and/or discharge test.**

This was the patient's Interim FCE. It lasted two hours; therefore, $100.00 should be reimbursed for each unit per MFG..[sic] Refer to the HCFA form to confirm **the** number of units performed for this date of service. Also refer to the Medical Fee Guidelines to confirm the previous."

2. Respondent: No position statement.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 09/12/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier a total of $200.00 for services rendered on the above date in dispute.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor a total of $100.00 for services rendered on the above date in dispute.

5. Per the Requestor's Table of Disputed Services, the amount now in dispute is $100.00 for services rendered on the above date in dispute.

6. The Carrier's EOB denies additional reimbursement as, "F FEE GUIDELINE MAR REDUCTION".

7. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
09/12/01	97750 FC	$200.00	$100.00	F	$100.00/hr	MFG; MGR (I) (11) (E); CPT Descriptor	The Carrier's EOB denies additional reimbursement as, "F FEE GUIDELINE MAR REDUCTION". A position statement from the Carrier, to support their denial of additional monies, is not found in the dispute file. Provider has submitted medical documentation to support services rendered in accordance with the MFG. Therefore, additional reimbursement of **$100.00** is recommended.
Totals		$200.00	$100.00				The Requestor **is** entitled to reimbursement in the amount of **$100.00**.

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **$100.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 16th day of September 2002.

Denise Terry, R.N.
Medical Dispute Resolution Officer
Medical Review Division

DT/dt